PUBLIC HEALTH, WELFARE & SAFETY

Exhibit No. #2

Date 1-12-09

Bill No. —

CURRICULUM VITAE (abbreviated)

Tom Roberts, M.D.

Current Positions:

President, Western Montana Clinic, 1991 to 1999 and 1/2007 to present. *The Western Montana Clinic, is a 60 provider multi-specialty medical group located in Missoula since 1922. WMC has offices on both Saint Patrick and Community Hospital campuses and supplies primary and specialty care to over 60,000 individual patients annually with over 130,000 visits.*

Board member Tamarack Medical Inc., 1/2007 to present, co-founder and chair of board 1998- 2001 and board member through 2005. *Tamarack Medical Inc. is a medical service organization that supplies billing & collections, accounting, nursing services, electronic medical records, and all other office support for the Western Montana Clinic, Montana Cancer Specialists, Missoula Surgical Specialists, the International Heart Institute, and the Lolo, Florence, and Frenchtown Medical Clinics.*

Clinical work, part time, with Western Montana Clinic Urgent Care, Saint Patrick Hospital Inpatient Physician Services, and Missoula City/County Partnership Health Clinic HIV program.

Recent Positions:

Internal Medicine, Western Montana Clinic, 6/1981 to 3/2006. *I practiced general Internal Medicine for 25 years in Missoula. Board certified in 1981, with added qualifications in Geriatric Medicine in 1988. My practice was 75% Medicare patients.*

Saint Patrick Hospital, In Patient Hospitalist Service 3/2006 to 3/2007. *Along with one other internist, I started the hospitalist program at SPH and worked there for one year. I continue with occasional coverage for shifts in this program which has grown considerably.*

Montana Health co-founder 9/1997 and board chair 2003- 2004. *Montana Health was a joint venture Health Maintenance Organization, formed by the Western Montana Clinic and Blue Cross and Blue Shield of Montana.*

Medical Director, Hillside Nursing Home, 6/1985 to 3/2006. *I have always enjoyed work with the elderly in many different venues.*

Additional Involvement/Interests

Married for 30+ years to Lindsay Richards, M.D., who practiced obstetrics and gynecology at the Western Montana Clinic from 1981 to 2006. Two grown children, one with Asperger's Syndrome.

Commentator on local National Public Radio station for past 8 years on health care organizational issues. Work with Montana Health Care Forum over past year and with Senator Baucus' health advisory committee past few months. Previously with various Saint Patrick Hospital committees/chairs, and community boards including Missoula Aids Council, Mountain West Home Health, and Chalice of Repose.

"thoughts about improving the delivery of health care in Montana, and the way it is reimbursed"
"what changes and or reforms can be made with and without legislation to make high quality health care for Montanans more affordable and accessible."
'which forum recommendations with and without legislation that I support"

Tom Roberts, M.D.
Practiced general Internal Medicine in Missoula for 25 years, from 1981 to 2006
Special interest in geriatrics. On leaving primary care 75% of my patients were over the age of 65.
Particular interest in the organization of health care, in my community, my state, and on a national level.

Western Montana Clinic

Founded 1922
40 physicians, 20 mid-levels, over 50% primary care
Serve 60,000 individual patients/year, with 160,000 visits
$40 million dollar/year
1/3 of our patients Medicare, Medicaid, other government programs
Associated through Medical Services Organization with 3 rural practices, and cardiology, oncology and surgery groups
Relatively small player overall, Great Falls Clinic has over 100 providers,
In Missoula, SPH, CMC, Partnership, VA all with employed primary care physicians

"what changes and or reforms can be made with and without legislation to make high quality health care for Montanans more affordable and accessible."

According to a 2007 study by the Commonwealth Fund, Montana ranks 46th among states in terms of access.
The national Department of Health and Human Services estimates that 150,000 Montanans lack access to a primary care physician, resulting in $55 million dollars in preventable emergency room visits.

Close to ½ of all Americans have at least one chronic disease, they incur 80% of all medical spending
2/3rds of all Medicare spending is on people with 5 or more chronic conditions
These are the people who need continuous, comprehensive, coordinated and affordable care, yet the ability to get that care is eroding

Among developed countries, U.S. is lowest in primary care functions, lowest in health care outcomes, and highest in costs.
In the U.S., levels of primary care are directly related to better health outcomes and lower costs.
Primary care physicians reduce hospitalization rates and improve quality measures.

There are dramatic differences in health care spending across the U.S. These spending rates are directly related to the number of specialists and hospital beds, and inversely related to the provision of primary care.

The basis of a quality, affordable, and accessible health care system is a robust primary care system.

American College of Physicians stated in 2006 that U.S. primary care system is on the verge of collapse.
Not only are docs leaving, but they are also not choosing primary care.
2% of graduating seniors in U.S. medical schools plan a career in general Internal Medicine.
Number of graduates choosing Family Practice has dropped by 50% in last 10 years.

What is to be done?

1) Understand the extent of the problem here in Montana.
    - Massachusetts experience
    - No accurate understanding of supply, needs in Montana
    - Montana Health Policy Council (Senate Bill 44)
2) support development of federally funded primary care access clinics
    - Will need adequate staffing
    - Nationwide shortfall estimated at 35 – 44,000 adult primary care physicians by 2025
3) support national efforts
    - ½ of recommendations Baucus Health Advisory Committee re improved/expanded primary care
    - National Physician Workforce Committee
    - Daschle "Critical" Federal Health Board, like Federal Reserve Board
4) "Value" based purchasing

Institute of Medicine, 2001, **Crossing the Quality Chasm**
Called for "fundamental change in our medical delivery system"
"The current system will not work. New information technology should be embraced and new systems of care developed. Methods of payment must be modified to encourage and reward quality care"
Health care needs of the American public have shifted from predominantly acute episodic care to care for chronic medical conditions.
Identify at least 15 priority chronic conditions and convene purchasers, providers, and health care organizations to develop models for payment and management of these diseases.
Currently being done in a number of states, not yet in Montana
Montana Health Care Forum, Value group
Meeting of provider groups (Bozeman, Billings, Helena, Missoula) insurers and employers, with national organization "Bridges to Excellence" to discuss and plan for ways to measure and reward quality care in management of chronic conditions.
Infrastructure of electronic medical records now in place in these communities
Role for Policy Council, state employees, University system

Statement for the Record
of the
American College of Physicians
to
the Senate Finance Committee

"Aligning Incentives: The Case for Delivery System Reform"

September 16, 2008

The American College of Physicians (ACP) is the largest medical specialty society in the United States, representing 126,000 internal medicine physicians and medical student members. ACP commends Chairman Max Baucus and Ranking Member Charles Grassley for holding this hearing on health system reform and aligning incentives to improve the quality of health care for patients. The College has been at the forefront of the effort to reform the health care system through its efforts to increase the number of primary care physicians and to reform Medicare payment systems to align incentives for physicians with delivery systems that can achieve improved outcomes for patients, such as the Patient-Centered Medical Home. We commend the Senate Finance Committee, under the leadership of Chairman Baucus and Ranking Member Grassley, for supporting policies to improve payments for primary care services, to provide additional funding to the Medicare Medical Home demonstration project, and to provide relief from payment cuts resulting from the flawed Sustainable Growth Rate (SGR) formula.

The Importance of Primary Care In Achieving Better Outcomes and Cost Savings

A fundamental goal of delivery system reform should be to recognize and support the value of primary care in improving outcomes; reducing preventable over-utilization of emergency rooms, hospitals and testing facilities; and achieving overall costs savings.

Evidence from over 100 references has found that primary care, such as care provided and managed by an internal medicine physician (internist), consistently is associated with improved outcomes and lower costs. ACP will soon be publishing a comprehensive and annotated literature review on the impact of primary care on quality and costs of care, which we will be glad to share with the Senate Finance Committee. Highlights include the following:

- When compared with other developed countries, the United States ranked lowest in its primary care functions and lowest in health care outcomes, yet highest in health care spending.[i ii iii]

- Primary care has the potential to reduce costs while still maintaining quality.[iv v vi vii]

- States with higher ratios of primary care physicians to population have better health outcomes, including mortality from cancer, heart disease or stroke.[viii ix]

- Individuals living in states with a higher ratio of primary care physician to population are more likely to report good health than those living in states with a lower such ratio.[x]

- The supply of primary care physicians is also associated with an increase in life span.[xi] [xii] An increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons.[xiii]

- Primary care physicians have also been shown to provide better preventive care compared to specialists, reflecting their ability to better manage the whole health of patients.[xiv] [xv] [xvi]

- The preventive care that primary care physicians provide can help to reduce hospitalization rates.[xvii] [xviii] [xix] [xx] [xxi]During the year 2000, an estimated 5 million admissions to U.S. hospitals involved hospitalizations that may have been preventable with high quality primary and preventive care treatment; the resulting cost was more than $26.5 billion. Assuming an average cost of $5,300 per hospital admission, a 5 percent decrease in the rate of potentially avoidable hospitalizations alone could reduce inpatient costs by more than $1.3 billion.[xxii]

- Hospital admission rates for five of 16 ambulatory care-sensitive conditions "for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease," increased between 1994 and 2003, suggesting worsening in ambulatory care access or quality for those conditions.[xxiii] [xxiv]Studies of certain ambulatory care-sensitive conditions have shown that hospitalization rates and expenditures are higher in areas with fewer primary care physicians and limited access to primary care.[xxv]

- An increase of one primary care physician per 10,000 population in a state was associated with a rise in that state's quality rank and a reduction in overall spending by $684 per Medicare beneficiary.[xxvi] By comparison, an increase of one specialist per 10,000 people was estimated to result in a drop in overall quality rank of nearly nine places and increase overall spending by $526 per Medicare beneficiary.

The Primary Care Physician Workforce is Facing Collapse

Despite strong evidence that primary care contributes to better outcomes for patients and overall cost savings, the primary care physician workforce is headed towards collapse. Demand is growing, at the same time that few young physicians are choosing primary care and many established physicians are leaving primary care practice.

Primary Care Supply is Declining while Demand is Growing

- The U.S. population is expected to increase 18 percent between 2005 and 2025, to 349 million. Within the next decade, the baby boomers will begin to be eligible for Medicare. By the year 2030, one fifth of Americans will be above the age of 65, with

an increasing proportion above age 85. The population age 85 and over will increase 50 percent from 2000 to 2010.[xxvii]

- This rapid growth in population and increased proportion of elderly people is expected to raise the number of ambulatory care visits by 29 percent by 2025. The increased child population is estimated to increase patient visits by 13 percent.[xxviii]

- The number of patients with chronic diseases, who benefit most from the coordination of care and continuity in care that primary care physicians provide is also increasing. Nearly 45 percent of the U.S. population has a chronic medical condition and about half of these, 60 million people, have multiple chronic conditions.[xxix] For the Medicare program, 83 percent of beneficiaries have one or more chronic conditions and 23 percent have five or more chronic conditions.[xxx]By 2015, an estimated 150 million Americans will have at least one chronic condition.[xxxi] Approximately two-thirds of the 133 million Americans who are currently living with a chronic condition are over the age of 65. Among adults ages 80 and older, 92 percent have one chronic condition, and 73 percent have two or more.[xxxii] Among nonelderly adults, the number who report having one or more of seven major chronic conditions has increased from 28 percent in 1997 to 31 percent (or 58 million) in 2006.[xxxiii]

While the demand for primary care is increasing, there has been a dramatic decline in the number of graduating medical students entering primary care and an exodus of established primary care physicians from practice. Factors affecting the supply of primary care physicians include excessive administrative hassles, high patient loads, and declining revenue coupled with the increased cost for providing care.

- A 2007 study of fourth-year medical students' career decision making revealed that only 2 percent of students intended to pursue careers in general internal medicine.[xxxiv]
- In 2007, only 14 percent of first- year internal medicine residents planned to pursue careers in general medicine. Among third-year internal medicine residents, only 23 percent planned to practice general internal medicine compared to 54 percent in 1998. From 1997 to 2005, the number of US medical graduates[xxxv]entering family medicine residencies dropped by 50 percent.[xxxvi]
- An increasing proportion of new primary care physicians are females, who tend to work fewer hours, further reducing the effective workforce. By 2025, half of all primary care physicians will be female.[xxxvii]
- A 2008 study predicted a 20 percent shortage, and possibly 27 percent if the decline in primary care Match rates continues, of adult primary care physicians by 2025. This translates into a shortfall of an estimated 35,000–44,000 adult primary care physicians. Further, greater use of nurse practitioners and physicians assistants and increased primary care by specialists are not expected to make enough of an impact on this shortfall.[xxxviii]

Established primary care physicians are also leaving practice at much higher rates than specialists. Approximately 21% of physicians who were board certified in the early 1990s have left internal medicine, compared to a 5% departure rate for internal medicine subspecialists.[xxxix]

Many communities throughout the United States already are experiencing shortages of primary care physicians, and many more will soon join their ranks. For example, the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services estimates that 150,308 Montana residents lack access to a primary care physician, resulting in $54,444,985 in annual expenditures on preventable emergency room visits. 339,747 residents of Iowa lack access to a primary care physician, resulting in $183,880,125 in preventable emergency room admissions. A state by state estimate of the shortage of primary care physicians and the impact on preventable emergency room visits is available at [http://nhsc.bhpr.hrsa.gov/about/reports/reauthorization/appb.htm].

A shortage of primary care physicians will undermine efforts to expand health insurance coverage. A health insurance card will not assure access to care if there are not enough primary care doctors. ACP strongly supports the goal of providing all Americans with health insurance coverage, but as Massachusetts's recent experience has shown, policies to expand coverage must go hand-in-hand with policies to reverse the shortage of primary care physicians.

The Boston Globe reported on September 22 that many of those in Massachusetts, a state that has pioneered policies to expand heath insurance coverage, must wait months to get an appointment with a primary care doctor:

> "The wait to see primary care doctors in Massachusetts has grown to as long as 100 days, while the number of practices accepting new patients has dipped in the past four years, with care the scarcest in some rural areas. Now, as the state's health insurance mandate threatens to make a chronic doctor shortage worse, the Legislature has approved an unprecedented set of financial incentives for young physicians, and other programs to attract primary care doctors. But healthcare leaders fear the new measures will take several years to ease the shortage. Senate President Therese Murray, who championed the legislation, said that many of the roughly 439,000 people who obtained health coverage under the 2006 insurance law are struggling to find a doctor. 'You can take a look at the whole state and you are not going to find a primary care physician anytime soon,' she said in an interview. 'It became apparent very quickly that we needed to do something.'

How Medicare Payment Policies Undermine Primary Care

Despite the overwhelming evidence that shows the ability of primary care physicians to improve the health of patients, the federal government undervalues the work of primary care physicians. Medicare payment policies have contributed to a U.S. health care system that has contributed to the shortage of primary care physicians and does not serve the interest of patients:

- Medicare pays little or nothing for the work associated with coordination of care outside of a face-to-face office visit. Such work includes ongoing communications between physicians and patients, family caregivers, and other health professionals on following recommended treatment plans;

- Low fees for office visits and other evaluation and management (E/M) services provided principally by primary care physicians discourage physicians from spending time with patients;

- Low practice margins make it impossible for many physicians, especially in solo and small practices, to invest in health information technology and other practice innovations needed to coordinate care and engage in continuous quality improvement;

- Medicare's Part A, B and D payment "silos" make it impossible for physicians to share in system-wide cost savings by organizing their practices to reduce preventable complications and avoidable hospitalizations.

- Medicare does not control volume or create incentives for physicians to manage care more effectively;

- The Sustainable Growth Rate (SGR) formula cuts payments to the most efficient and highest quality physicians by the same amount as those who provide the least efficient and lowest quality of care; penalizes physicians for volume increases that result from following evidence based guidelines; triggers across the board payment cuts that have resulted in Medicare payments falling fall short of inflation for hard-pressed primary care practices that are struggling to keep their doors open; and forces many physicians to limit the number of new Medicare patients that they can accept in their practices;

Redesigning Payment Policies to Align Incentives with Quality and Efficiency

ACP urges Congress to enact comprehensive reforms of Medicare payment policies to align incentives with quality and efficiency of care in a way that recognizes and supports the central role of primary care physicians in achieving better outcomes at lower costs. We are pleased to report that we are working with Senator Maria Cantwell, a member of the Senate Finance Committee, on a bill that would realign Medicare payment policies to support patient-centered primary care. The bill will also include loan forgiveness and scholarships for internists, family physicians, and pediatricians who agree to provide primary care in a facility or geographic area that is facing a critical shortage of primary care physicians. It is our understanding that Senator Cantwell will be introducing the bill early in the 111th Congress. Among the payment reforms that are being considered for inclusion in the bill are provisions to provide immediate payment increases for evaluation and management services provided principally by primary care physicians, changes to take into account the impact of primary care on reducing overall Medicare program costs, coverage and payment for specific services relating to care coordination by primary or principal care physicians, and transition to a new payment methodology for primary care practices organized as Patient-Centered Medical Homes (PCMHs). We recommend the following:

1. **Reform Medicare fee-for-service payments by providing <u>immediate, sufficient and sustained</u> payment increases for services provided principally by primary care physicians.** Such reforms should include:

TRENDS

Eroding Access Among Nonelderly U.S. Adults With Chronic Conditions: Ten Years Of Change

While the uninsured fared the worst, more adults with health coverage also found it hard to afford care by 2006.

by Catherine Hoffman and Karyn Schwartz

ABSTRACT: Both the connection to health care and its affordability worsened for many nonelderly U.S. adults living with chronic conditions between 1997 and 2006. This erosion varied by health insurance coverage, fundamental as it is to securing health services. Access to care among uninsured adults with chronic conditions deteriorated on all of our basic measures between 1997 and 2006. In addition, more of both the privately and publicly insured with chronic conditions went without health care because of its cost over this ten-year span, even while they were just as likely as or more likely than others to have a usual source of care over time. [*Health Affairs* 27, no. 5 (2008): w340–w348 (published online 22 July 2008; 10.1377/hlthaff.27.5.w340)]

MORE THAN 40 PERCENT of the U.S. population lives with one or more chronic conditions. However, because people with chronic conditions have greater health needs than others, they account for three-quarters of all personal medical care spending in this country.[1] And yet we know that many people with chronic conditions have problems getting health care, particularly if they have no health insurance coverage. Given the swings in the economy and family incomes in the past decade, as well as the growth in health care costs and the number of uninsured Americans, we measured whether the insurance disparities in access to care among those with chronic conditions have changed. We focused on nonelderly adults with chronic conditions, knowing that their greater need for and use of health services make them sensitive to these changes. All of the research to date on access to care for this population was conducted before 2000, and no studies have measured changes in access to care among those with chronic conditions over this long of a period.

Background

The chances of having a chronic condition increase with age—particularly among the elderly, nearly all of whom have Medicare coverage. However, the majority (60 percent) of people with chronic conditions, about sixty-five million, are working-age adults.[2] Nonelderly adults with chronic conditions are more likely than others to have health insurance, partly because they know that their health needs will be greater, and so insurance is even more essential to them, but also because those who become disabled may qualify

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DOI 10.1377/hlthaff.27.5.w340

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Improving Accountability for the Public Investment in Health Profession Education

It's Time to Try Health Workforce Planning

David C. Goodman, MD, MS

THERE IS WIDESPREAD DISCONTENT WITH TODAY'S health workforce and its training pipeline. Patients cannot find primary care physicians who are accepting new patients and have difficulty navigating care that is fragmented over increasingly specialized clinicians. Some organizations warn that there will soon be a large gap in the number of physicians required to meet projected increases in patient utilization.[1] Others point out that clinicians are ineffectively and inefficiently deployed across regions and predict that increases in the number of physicians will lead to an increase in expensive and marginally useful services that fail to improve health outcomes.[2] The primary care workforce has been depleted by a shift of generalists to specialist, hospitalist, and emergency department services; little relief should be expected from the youngest physicians, who have a declining interest in primary care.[3] Attention of workforce planners to the role of nonphysician clinicians is perfunctory even as the numbers and autonomy of nurses and physician assistants increase. Programs demonstrated to be highly effective in attracting physicians to care for underserved populations remain underfunded.[4,5] Little progress has been made in improving racial and cultural diversity in clinicians, and many programs charged with doing so have been eliminated.[6]

Just as nature abhors a vacuum, so does public policy. The troubled health workforce does not reflect misguided public policy but a near absence of policy. In the policy vacuum, outdated workforce programs are coupled with entrenched professional self-interests and political inertia to hinder desperately needed change.

Three articles in this issue of *JAMA* demonstrate the consequences of the workforce policy vacuum. Hauer and colleagues[7] queried more than a thousand fourth-year medical students at 11 US medical schools about their decision making regarding internal medicine as a specialty choice. The study's most startling finding is that only 2% of the students planned a career in primary care

See also pp 1131, 1154 and 1174.

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internal medicine and that only 19% reported that the attractiveness of a career in general internal medicine was favorably influenced by their core medicine clerkship. Although international medical graduates can help fill the primary care training positions, the lack of interest by US medical students in primary care should sound warning bells for health systems and the already tenuous safety net.

The analysis by Ebell[8] confirms his 1989 study[9] and the view that "white follows green"[10] by demonstrating a persistent strong correlation between US medical students' specialty choice and the overall mean salaries of those specialties. Only those with an uncritical trust in the medical markets will accept that the salaries paid to orthopedic surgeons, radiologists, and otolaryngologists signal their greater importance to patients than general internists, pediatricians, and family practitioners. Ironically, while these powerful economic forces are allowed to dictate the shape of the health workforce with minimal public influence, there are calls to increase the public subsidization of medical education.[1]

The study by Salsberg and colleagues[11] tracks the changes in numbers of graduate medical education (GME) trainees during the past decade, a period when Congress constrained the increases in Medicare GME funds. After the 1997 Balanced Budget Act, increases in GME positions paused for 5 years and then resumed an upward direction. During 2002 to 2007, new physician GME entrants increased by 7.6%, with the largest relative increases occurring in nuclear medicine, neurology, plastic surgery, otolaryngology, and neurological surgery. The percentage of all residents likely to practice in primary care decreased from 28% to 24%.

These changes did not occur by conscious public design. In today's policy vacuum, workforce "planning" is the collective decisions of hundreds of teaching hospitals—to downsize the number of family medicine residents, to start a new otolaryngology program, or to expand the size of internal medicine subspecialty fellowships. Teaching hospitals do not have the necessary information and have never been charged with calibrating their training programs' size and specialties to public health or health system goals. Instead, decisions reflect institutional priorities, and patients are left with a workforce increasingly differentiated into terminal subspecialties.

Most other developed countries view public planning of the clinical workforce as an essential partner to the public funds that pay for medical education.[12] For example, public guidance joined together with market forces are essential to the functioning of the health care systems and medical education in both England and Germany. Planning in England's National Health Service (NHS) begins with identifying patient needs, followed by setting targets for staffing and training. The planning process is highly centralized with decisions about the clinician staffing of the NHS directly linked to the funding of medical schools and to postgraduate training positions.[13] Although Germany has a more complex mixture of physician employment and payment, funding of health services is also publicly guided. Similarly, public policy strongly directs medical education, including medical education curriculum.[14] This coupling of public medical education funding and workforce planning tempers medical school and hospital interests with broader perspectives about the numbers of physicians and specialties needed in the future. The results are never perfect, but when workforce policy in European countries misses the mark, new policies can be more quickly implemented than in the United States.

In the United States, the primary public body concerned with the medical workforce is the Council on Graduate Medical Education (COGME), which has served as the principal advisor to Congress on the physician workforce for 22 years.[15] During that time, COGME has issued 19 reports that have discussed the full range of physician workforce issues with little visible impact on medical training. The most recent report from COGME raises its own concerns about the current policy structure and argues for greater GME oversight: " . . . COGME recommends that the public good GME represents should be made explicit, accountable, and subject to regular and rigorous evaluation and management."[16] Recently the Association of Academic Health Centers has called for "establishment of an inclusive planning body to create a national workforce agenda and promote a sound national health workforce policy."[17]

COGME limitations should be understood so that they are not repeated. COGME policy brief is limited to physicians and primarily to GME. There is no explicit charge to coordinate with other federal bodies concerned with clinical workforce, such as the National Advisory Council on Nurse Education and Practice and the Advisory Committee on Training in Primary Care Medicine and Dentistry. The composition of COGME is entirely physicians, largely from teaching hospitals, without meaningful representation of patient, public health, and delivery system stakeholders. The authorization for COGME expired in 2002 and its budget is currently at the discretion and the political influence of the Secretary of Health and Human Services.[18] COGME relies on the Health Resources and Services Administration for staff support, although its expertise in the health workforce has almost vanished with the elimination of the National Center for Health Workforce Information and Analysis and federally funded regional workforce centers. In contrast, the Medicare Policy Advisory Council has robust staff support with 19 analysts to assist it in formulating its recommendations.

Major reform of the US health care system is once again on the political agenda. Successful reform will require more

effective workforce planning. The United States should establish a permanent health workforce commission that can help overcome the current limitations of health professions training. Five principles should guide the commission's charter. First, the public interest in the workforce should be articulated. What should be expected for the national investment in the health workforce? The specific aims should be to craft evidence-based policy that improves access to care, quality of care, health outcomes, and the affordability of care.

Second, the membership of the commission should be broad and include experts in public health, patient-centered care, and epidemiology, as well as clinicians, consumers, innovative and efficient health systems, payers, and medical educators. Third, the commission should consider policy related to health clinicians of all types. Workforce planning requires inclusive consideration of clinicians required to meet patient needs.

Fourth, an evidence-based approach to workforce policy formulation requires a dedicated staff to develop the expertise for evaluating the workforce and the likely effect of policy recommendations. This staff needs to engage with health services researchers who are independent of the analytic groups of professional societies and trade associations that are potentially conflicted by changes in workforce policy.[19] Fifth, Congress should provide the commission with an increasing degree of regulatory responsibility that insulates reform from the self-interests of training programs and clinicians.

The expected argument against accountability is that it is wiser to allow market forces to decide the fundamental questions of workforce size and composition. However, doing so practically assures maintaining the status quo. It is unreasonable to expect that market forces will self-organize an effective health workforce. It is time to try public health workforce planning.

Financial Disclosures: None reported.

Funding/Support: Dr Goodman is supported in part by the Robert Wood Johnson Foundation and grant PO1 AG019783-07 from the National Institute on Aging.

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